Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRESBYTERIAN HOSPITAL PLANO
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-06-1170-01

MFDR Date Received
October 12, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We also believe the payment made by the carrier does not match fairly to what medicare has calculated according to the DRG set to the services rendered. DRG 35, according the medicare reimbursement schedule warrants a reimbursement of $17,335.95, which is substantially lower than what was allowed by the carrier. We do not feel that anything less than what medicare would have allowed is neither fair nor reasonable. . . . Implant cost were $23,790.00 plus 10% for a total due on implants of $26169.00, non of which has been paid."

Amount in Dispute: $10,764.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor bears the burden of proof in this matter. . . . Because Requestor has not met its burden of demonstrating unusually extensive services, and the documentation adduced thus far fails to provide any rationale for the Requestor's qualification for payment under the Stop-Loss Exception, Respondent appropriately issued payment per the standard Texas surgical per diem rate. No additional monies are due to the Requestor. "

Response Submitted by: Hanna & Plaut LLP, Southwest Tower, 211 E. 7th Street, Suite 600, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2004 to November 16, 2004	Outpatient Hospital Services	$10,764.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401 was the Division's former Acute Care Inpatient Hospital Fee Guideline.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on October 12, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 27, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z585 – THE CHARGE FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE. (Z585)
   - Z652 – [No explanation of this reason code was found in the submitted documentation.]
   - X023 – PAYMENT FOR THIS CHARGE IS NOT RECOMMENDED WITHOUT DOCUMENTATION OF COST. (X023)

Findings

1. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
4. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
5. 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
6. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - Review of box 4 of the hospital bill finds that the provider billed the services in dispute with Type of Bill code 131, indicating a hospital outpatient admit through discharge claim. Based on the submitted information, the Division finds that the disputed services are outpatient hospital services. Outpatient surgical care did not have an established fee guideline during the time period that the disputed services were rendered. Therefore, the applicable rule for reimbursement is 28 Texas Administrative Code §134.1, which requires that these services shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011.
   - The requestor's position statement asserts that "the payment made by the carrier does not match fairly to what medicare has calculated according to the DRG set to the services rendered. DRG 35, according the medicare reimbursement schedule warrants a reimbursement of $17,335.95, which is substantially lower than what was allowed by the carrier. We do not feel that anything less than what medicare would have allowed is neither fair nor reasonable."

- The Division notes that Medicare would not have reimbursed the provider under Diagnosis-Related Group (DRG) 35 on an outpatient bill, as the DRG classification system used by Medicare solely to calculate reimbursement for inpatient admissions. Medicare does not employ DRG's in calculating reimbursement under Medicare's Outpatient Prospective Payment System for hospital outpatient bills.
- The requestor did not explain why a reimbursement methodology using Medicare's reimbursement system for inpatient services should be applicable to outpatient services such as the services in dispute.
- The requestor has not explained or provided documentation to support how payment of the disputed services according to the Medicare reimbursement schedule using DRG 35 would provide for a fair and reasonable reimbursement for the services in dispute.
- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients, (22 *Texas Register* 6284, July 4, 1997), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services." Therefore, a reimbursement amount that is taken directly from the Medicare fee schedule or calculated based solely on conversion factors or other payment adjustment factors developed by the federal Centers for Medicare and Medicaid Services cannot be favorably considered when no other data or documentation was submitted to support that the amount paid is a fair and reasonable reimbursement for the services in dispute.
- Additionally, the requestor states "Implant cost were $23,790.00 plus 10% for a total due on implants of $26169.00, non of which has been paid."
- As above, the Division notes that the former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute; per §134.401(a)(4), effective August 1, 1997, 22 *Texas Register* 6264, "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements." Therefore, the applicable rule for reimbursement of these services is §134.1, which provides for fair and reasonable reimbursement of services not identified in an established fee guideline.
- The requestor did not demonstrate or provide documentation to support that reimbursement for implants provided in an outpatient hospital setting should be comparable to reimbursement for implants provided in an inpatient hospital setting.
- The requestor did not demonstrate or provide documentation to support that reimbursement of the cost of the implants plus ten percent would be a fair and reasonable reimbursement for the services in dispute.
- Moreover, the requestor has not submitted any medical records to support that any of the implants or medical services were provided as billed.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 19, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.